

Physician's/Practitioner's Certification Form (for Catastrophic Leave)

1. Patient's Name: _____
2. Diagnosis: _____

3. Date condition commenced: _____
4. Probable duration of condition: _____
5. Treatment prescribed (*indicate number of visits, general nature and duration of treatment, including referral to other providers of health services. Include schedule of visits or treatment if it is medically necessary for the employee to be off work on an intermittent basis or to work less than the employee's normal schedule of hours per day or days per week.*) _____

6. Is inpatient hospitalization of the patient required? _____
7. If the patient is the employee, is the employee able to perform the functions of the employee's position? (*Answer after reviewing statement from employer of essential functions of employee's position, or if none provided, after discussing with employee.*) _____

8. If the answer to Question 7 is "No," is the employee able to perform work of any kind? When is the estimated time the employee will be able to perform the essential functions of his/her position? _____

9. If the patient is not the employee, does (or will) the patient require assistance for basic medical, hygiene, nutritional needs, safety, or transportation? _____

10. If the patient is not the employee, is the employee's presence necessary or would it be beneficial for the care of the patient? _____

11. Estimate the period of time the care is needed or the employee's presence would be beneficial: _____

Physician/Practitioner Signature: _____ Date: _____
Printed/Typed Name of Physician/Practitioner: _____
Type of practice/field of specialization: _____

Return to: Judy Beutler, Deputy State Court Administrator
Administrative Office of the Courts/Probation
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(402) 471-2921